DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	March 1, 2015	Initial version Uniform Managed Care Manual Chapter 5.6.1.9, "Nursing Facility Claims Summary Report Instructions." This chapter applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.
Revision	2.1	January 1, 2017	"Applicability of Chapter 5.6.1.9" is modified to add the STAR Kids program. "Data Entry for the Claims Summary Report" is modified to add the program designation. Version 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-13-0042, and 529-13-0071; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Applicability of Chapter 5.6.1.9

Applicability Modified by Version 2.1

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Kids and STAR+PLUS (including the Medicare-Medicaid Dual Demonstration) Programs. In this chapter, references to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR Kids and STAR+PLUS Programs. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs) and any other entities licensed or approved by the Texas Department of Insurance.

Objective

Managed Care Organizations (MCOs) contracting with the State of Texas to provide comprehensive health care services to qualified Program recipients must submit the Nursing Facility Claims Summary Report in accordance with the Contract for services between HHSC and the MCO, and in accordance with the instructions below. The requirements apply to claims for Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance unless otherwise noted. Ad Hoc reports may be requested by HHSC as needed.

For claims processing requirements for Nursing Facility Add-on Services, refer to UMCM Chapter 2.0, "Claims Manual."

General

The Claims Summary Report must be completed using the template provided by HHSC. Each MCO is required to submit a report for each Service Area. Claim types include Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance for Long-Term Services and Supports which are reported separately on an the 837 institutional (837i) transaction form.

All shaded data fields in the Claims Summary Report represent fields where data input is required. All data fields not shaded represent cell-referenced data or calculations.

HHSC will provide the Claims Summary Report to the MCOs in an electronic format. Spreadsheet integrity is critical to the automated compilation of this data. MCOs may not alter the file name, worksheet name, existing cell locations, or the format of the data in the cells. MCOs may not add or delete any columns or rows to the spreadsheet.

Please refer to Chapter 5.6.1.8, for the Nursing Facility Claims Summary Report Template.

Nursing Facility Claims Summary Report

The Nursing Facility Claims Summary Report will provide HHSC with information on Nursing Facility Unit Rate and Nursing Facility Medicare Coinsurance claims processed within the required timeframes. The claims processing requirements and required timeframes are presented in Chapter 2.3 Nursing Facility Claims Manual on the Uniform Managed Care Manual. Additional definitions are found in the MCO's Contract, including Attachment A and other chapters of the Uniform Managed Care Manual.

The Claims Summary Report must be submitted quarterly by the last day of the month following the reporting period.

Data Entry for the Claims Summary Report

Enter the following information on the Claims Summary Report.

Data Entry Modified by Version 2.1

Claims Processor: The MCO's official name in Texas, or if the MCO has subcontracted with a claim processor, enter the name of the subcontractor
Program: STAR Kids or STAR+PLUS
Service Area: For example, Bexar
State Fiscal Year: For example, 2014
Period: For example, Q1, Q2
Period start date: Month, day, and year, for example, 9/1/2014
Period end date: Month, day, and year, for example, 9/1/2014
Date Submitted: Month, day, and year, for example, 9/1/2014

Enter the following information.

Clean Claims Adjudicated during the period: include any claims ***Adjudicated*** between the dates specified as Period Start Date and Period End Date. The number of claims denied, the number of claims paid, and the amounts paid are to be entered according to the time between the date of receipt and the date of Adjudication (claims Adjudicated within 10 days of receipt, 11 to 90 days after receipt, and more than 90 days after receipt).

Column I, Row 15 calculates the percentage of Clean Claims Adjudicated within 10 days of receipt.

Appealed Claims Adjudicated during the period: include any Appealed Claims ***Adjudicated*** between the dates specified as Period Start Date and Period End Date. The number of claims denied, the number of claims paid, and the amounts paid are to be entered according to the time between the date of receipt and the date of Adjudication (claims Adjudicated within 30 days of receipt, 31 to 90 days after receipt, and more than 90 days after receipt).

Column I, Row 24 calculates the percentage of Appealed Claims Adjudicated within 30 days of receipt.

Adjusted Claims Adjudicated during the period: include any claims ***Adjusted*** between the dates specified as Period Start Date and Period End Date. Enter the number of claims and the additional amount paid.

Claims Processed during the period: include any claims ***Processed*** between the dates specified as Period Start Date and Period End Date. These claims, Rejected Claims, Duplicate Claims, Deficient-Denied Claims, and Deficient-Pended Claims, are to be reported according to the definitions in Chapter 2.3 of the Uniform Managed Care Manual.

Other Claims: include all Other Unprocessed Claims and Capitated Service Claims between the Period Start Date and Period End Date. These claims are to be reported according to the definitions in Chapter 2.3 of the Uniform Managed Care Manual.

Interest penalties paid to providers between the Period Start Date and Period End Date are to be reported on row 44. Enter the total number of claims subject to interest penalties, that is, Clean Claims, or any portion of Clean Claims, that remain unadjudicated beyond 10 days from the date of receipt and the amount of interest paid to those providers.